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ABSTRACT

This paper describes the Primary Prevention Project (PPP), a demonstration program of the Mendota Mental Health Institute in Madison, Wisconsin which provides services to multi-problem families with children under 3 years of age in order to prevent abuse and neglect, developmental delay, or future socio-emotional difficulty. The project's philosophy, organization, and development over the past 10 years are reviewed and a profile of clients served by PPP is included. Services offered by PPP which focus on parent-child interaction from birth are described and a service curriculum which follows the child's development is briefly outlined. Services discussed include instruction in infant massage, safety-proofing, training in play skills, and behavioral and child management techniques. The PPP treatment approach providing services in clients' homes is discussed with a special emphasis on how effective services can be delivered to multi-problem families. Five clusters of problems requiring special treatment are identified: parents who are emotionally disturbed; parents with cognitive limitations; families characterized by resistance, suspicion, and hostility; families characterized by disorganization; and families with mothers who are socially isolated, passive, and easily manipulated. Available PPP evaluation data are reviewed and the current status of the program is discussed. (NRB)

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INTERVENTION STRATEGIES FOR DEALING WITH MULTI-PROBLEM FAMILIES

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The Primary Prevention Project provides services to multi-problem families with children under 3 years of age in order to prevent abuse and neglect, developmental delay or future socio-emotional difficulty. Over the past 10 years, the Project has evolved on several dimensions, and the purpose of this paper is to share those developments which might be of interest to persons concerned about family systems and health. The discussion will cover the Project's philosophy and organization, its clientele, and its treatment approach with a special emphasis on how effective services can be delivered to multi-problem families. Although methodological problems limit the conclusions which can be drawn from available evaluation data, clinical experience indicates that problematic parent - child interactions can be modified; indeed, to anticipate the conclusion, it appears that all families with young children face similar difficulties and might benefit from similar services; the major difference with multi-problem families is in how those services must be delivered.

THE PROGRAM

The Primary Prevention Project (or PPP) is a demonstration program of Mendota Mental Health Institute in Madison, Wisconsin. It provides direct service to a limited number of families within Dane County while providing training and consultation to other service providers throughout the state. Services are provided in clients' homes by a multidisciplinary team. Although the size and diversity of that team have shrunk with diminishing resources, there are several reasons why that aspect of the organization is still emphasised. First, each member of the team serves as "case manager" for some of the clients; this is the person who coordinates the services, does most of the paperwork, and has most of the contact with the family. This facilitates accountability, but more importantly, it focuses attention on the relationship between the client and the case manager; one evaluation indicated that establishing rapport between client and case manager was a very important variable in predicting ratings of successful outcome, accounting for 24% of the variability in those ratings (Sallows et al., Note 1). The team structure guarantees that each client gets the benefit of each team member's special expertise, and it provides a structure for sharing of problems and frustrations among members of the team. The importance of

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this sharing in preventing burnout when working with multi-problem families cannot be overemphasized.

PPP has become progressively more structured with its intervention over time. Initially the staff sought to establish a relationship to support a troubled parent and might demonstrate different ways of interacting or stimulating that parent's child. This approach has gradually been replaced by a parent training model in which family needs are thoroughly assessed and then parents are taught skills that address those needs. As noted above, establishing a supportive relationship is still important, but not so much as an end in itself. Before discussing those skills and how they may be taught, let us consider the clients and their needs.

THE CLIENTS

Most families are referred to PPP by the county department of social services (42%) or by hospitals or pediatricians (33%). Currently 55% of the clients are referred for suspected abuse or neglect. Very few are self referrals.

The parents have limitations which make them unlikely to benefit from purely educational interventions. Nearly half (45%) are described as being "slow learners" by referral sources and thirty-six percent have received mental health services previously. Many parents have both intellectual and emotional limitations. Seventy percent received poor parenting themselves. Almost all are economically disadvantaged and the father is absent from the home in 64% of the cases. Age of the mother at admission ranges from 14 to 32 with a mean of 25 years; the Project serves relatively few teen age mothers because of the availability of an excellent school-based program for those women.

The child's age at referral ranges from unborn to 2.5 years with a median age of 6.7 months. Fifty-five percent are male. While some of the children appear to be developing normally, 60% are measurably delayed at the time of referral. Physical problems are found in about 15% of the children, and socio-emotional problems have already been identified in about 12% of the cases.

This profile is hardly surprising to most social service workers, but it is notably different from the population served by many parent training programs. Blechman (1984) reported that the typical family in behaviorally oriented parent training programs was a two-parent, white family with a mean income of over $11,000, and she argued that parent training is not the treatment of choice for parents who have not demonstrated their "competence" in other areas of life.

Blechman also reported that the children typically served by these programs are older (ranging from 3.5 to 8.8 years), predominantly male (73%), and are characterized by problems like disturbed parent-child relations, school problems, and anti-social behavior. Even Project 12-Ways (Lutzker, 1984), which directly targets abusive and neglectful families, focuses its training in parent child interactions on disciplinary issues with older children.

In contrast, PPP has developed services which focus on parent-child interaction right from birth, and "discipline" becomes the last issue to be dealt with rather than the first. Although services to a family are always individualized, and few families receive training in all areas (the mean length of treatment being about 10 months), the "curriculum" follows the child's development and can be quickly outlined here.

SERVICES

Meeting the neonate's needs for nourishment and physical care is the first challenge faced by a parent; fortunately, this is the challenge for which most assistance is available. Pediatric nurseries, public health visitors, WIC clinics and others are available to monitor and assist in meeting basic physical care needs. PPP's involvement at this stage tends to be limited and is often preventive in nature. Thus the baby's behavior is interpreted to the parents, who often have unrealistic expectations. Talking to the baby during physical care is encouraged as an early form of language stimulation but even more to build that habit in the parent. Assessments tend to focus on whether natural processes of bonding and attachment are occurring or not.

Almost simultaneously, crying becomes a problem. Indeed a baby who will not stop crying is one of the most frequent reasons given for presenting with an infant at an emergency room and a common antecedent of physical abuse (Kornberg & Kaplan, 1980). Again normalization of the behavior and shaping more realistic expectations is needed, but skills of soothing and of coping with the stresses of parenting are also taught (Kloss et al., Note 2). Many parents are concerned about "spoiling" their child and need to be reassured that picking up a crying infant is the right thing to do; if the parent received poor parenting him/herself, more than reassurance can be needed.

One skill that is helpful to both soothe the baby and manage parental stress is infant massage (Schneider, 1979). Many benefits have been claimed for infant massage, but the one which is emphasized by PPP is the cumulative relaxing effect massage has on both child and parent. Massage training

provides a good opportunity to discuss balancing the baby's need for care with the parents' own needs. At about this time respite care can be arranged, and single mothers especially are encouraged to get away from their baby and cultivate other interests.

Incorporating an infant massage into the daily routine also sets a pattern which is useful if the baby's development lags or special stimulation is needed. The Portage Project materials (Schearer & Schearer, 1972) or the commercially available "Small Wonder" kit are good sources of stimulation exercises. In PPP's experience, language stimulation exercises are most often needed, and the approach taken has been described in detail by Sallows and Smith (Note 3).

At about age 8 months, or when the baby becomes mobile, two services are generally needed, safety proofing and training in play skills. Safety proofing the environment directly reduces the risk of injury and subsequent charges of neglect (Tertinger et al., 1984) and it also provides an opportunity to normalize expectations about toddler behavior; it might be theoretically possible to feed the toddler without getting food on the floor and to leave the heirloom china within baby's reach, but it is not worth the effort. Far better to avoid problems by putting plastic underneath the highchair and move the china up out of reach. A fringe benefit is that the child is almost instantly perceived to be better behaved when some of the "no-no's" are eliminated.

The need for training in play skills may be less obvious. The importance of play in the child's development is well established, but it can be difficult for parents to appreciate and participate in play with a young child. They may well become bored with the repetitive banging, stacking and throwing that are common at this age, or they may become frustrated when the child does not play with a new toy "in the right way." Power struggles and negative responses by the child can develop easily, so perhaps it is not surprising that some of the most negative parent - child interactions have been observed during what was supposed to be "play." A high frequency of parent behaviors variously labeled as directive, teachy, controlling or intrusive are considered problematic when observed during play interactions. PPP's assessment procedures now look for this kind of behavior, and a technique called Responsive Special Play has been developed to provide an alternative set of play skills (Sallows et al., Note 4). Responsive Special Play is probably the skill most often taught to PPP parents, and it should be described in some detail.

Responsive Special Play emphasizes play at the child's own level in order to avoid making the child feel intruded upon,

and it increases awareness and sensitivity between parent and child. Parents are asked to spend 10 to 30 minutes per day doing Responsive Special Play with their children. During this period, the parent's time belongs totally to the child. The parent must be positive, rested and unstressed. This usually means that a particular time of day needs to be selected when the parents can be at their best and the play will be uninterrupted. This is also true for the child, who needs to be rested, fed and diapered. Setting up these preconditions in itself sets the stage for more positive interactions. The parent sits on the floor with the child in a safety-proofed environment. With only a few toys near them, the parent waits for the child to begin. The child initiates -- the parent follows. The parent cannot teach, initiate or change what the child does; the child is "in charge," much as in a game of Follow the Leader. The child discovers, explores, experiences and learns in his or her own way, at his/her own pace. The parent learns about the child by watching, imitating, labeling and describing. The parent stays within 12 - 18 inches of the child; if the child moves, the parent follows, sometimes actually turning into a chase game. The parent should avoid correcting the child or reacting negatively to any of the child's actions. (Of course this is only possible in a thoroughly safety-proofed environment). The parent should not compete or play independently, but imitation of the child's behavior is encouraged. Responsive talk -- commenting on what the child is doing, interpreting the child's behavior, and repeating the child's vocalizations -- is also encouraged. The parent is taught how to keep play positive by praising, smiling and touching the child.

No matter how positive the first 12 to 15 months of child's life are, however, the challenges to parents known colloquially as "the terrible two's" are inevitable. Indeed they are developmentally necessary, but parents also need to know how to cope with a whole range of normal "misbehavior," i.e. whining, hitting, non-compliance. PPP teaches a full repetoire of behavioral techniques that includes giving specific praises for desired behavior, ignoring some misbehaviors while redirecting the child from some others, use of clear directives, physical prompting for compliance and time out from positive reinforcement for serious misbehavior (Sallows et al., Note 5). These child management techniques are not much different from those developed at the Universities of Kansas or Oregon or by Mendota's own Home and Community Treatment Program except that they have been modified to be applicable with children as young as about 12 months. There are also prerequisites before these techniques can be used effectively; the child's physical environment should be structured to eliminate as many problems as possible and to support desired behavior, parents must have realistic

expectations of their children, and a positive parent-child relationship must exist.

Please note that although the curriculum described above implies a commonality of needs among PPP's clients, the commonalities are not related to the characteristics that define the client population or high risk families generally (Solnit & Provence, 1979). The parenting problems PPP addresses are problems of normal development that must be faced by all families; the special needs of PPP's clientele are addressed not so much in what they are taught but in how they are taught. The next session of this paper describes the intervention strategy used by PPP in more detail and considers some issues raised by different clusters of client problems.

TREATMENT STRATEGY

The importance of PPP's organizational structure, combining the resources of a team with the accountability and the potential for 1:1 relationship provided by a case manager has already been mentioned. Even more important is that services are provided in the clients' homes. The first reason for this is that the intended clients are not likely to attend clinic or center based programs. Non-participation may be the result of practical problems, like transportation difficulties, it may be related to problems of poor coping skills generally, i.e. difficulty in using public transportation even if it is available, or it may indicate a lack of motivation. Going to the families at home solves the problem whatever the reason. Secondly, providing services at home improves the effectiveness of services. Visiting a family at home is an expression of caring and thus can help build rapport. It allows staff to see problems as they really occur, not as they are reported after the fact, and it increases the chances that newly learned skills can and will be applied in the natural setting (Stokes & Baer, 1977).

Providing services in the home is not without problems however. It increases the cost of service appreciably since about one hour of travel time is needed for every hour and a half of service and because service cannot be provided to clients in groups. The lack of group involvement in PPP's treatment strategy deserves special comment. Groups provide better opportunities for social support by peers, for modeling of appropriate behaviors and for informal sharing of resources that are not possible otherwise, and Wolfe, Kaufman, Aragona adn Sandler (1981), among others, have reported excellent success with group formats; PPP's experience has been less positive. The logistical problems of providing transportation and baby sitting services so parents could attend a group have been formidable, and both participation and outcome when groups

have been tried have been disappointing unless opportunities for supervised practice of new skills are included in the group structure. It may be that PPP clients do not have the social and coping skills to successfully form a group themselves or to join a group of better functioning parents. More to the point, it seems that services must be focused tightly on each family's problems if treatment is to be successful, and group work tends to be more general and diffuse.

Maintaining a goal-focused intervention with each family is absolutely necessary, and PPP uses several techniques to accomplish this. First, the reason for referral is always restated to the family by the referring person during PPP's first contact with the family. Second, a standard assessment taking 4 to 6 weeks provides comprehensive information about both strengths and needs; it also provides an opportunity for the rapport building that is so necessary before recommendations for change will be accepted. Third, services are provided through a contractual model. The assessment period ends with a "community meeting" where problems, goals and approaches are shared with the family and other agencies, and where voluntary, informed consent to treatment is obtained. Each month thereafter, consent is re-obtained on a monthly summary of case progress and future objectives, and mini-contracts are often made from session to session.

Contracting also facilitates breaking both the goals and approaches into small, discrete steps. For example, training in Responsive Special Play typically begins by only expecting the parent to stay physically close to the child for 5 minutes, and specific praise for desired behavior is always the first child management skill taught. Progress can be excruciatingly slow -- with one mother only one table in one room could be safety-proofed at a time, for example -- but trying to do more only leads to frustration for both parent and case worker.

Regardless of the goal, the approach should emphasize practicing a behavior rather than giving information or discussing a problem, and each new behavior can be taught in a step-wise fashion. The first step is to briefly but clearly describe the desired behavior. The behavior is then demonstrated to the parent, and the parent is asked to practice it with the case worker in a role-played situation. After those steps have been mastered, the case worker supervises while the parent practices with the child; cueing of the desired behavior is usually necessary, but praise for the parent's attempts should be more frequent by a ratio of 10:1. Practicing the new skill after the session should be agreed upon in a mini-contract; asking the parent to demonstrate the skill at the beginning of the next session is usually enough to determine if practice did take place.

The preceding paragraphs describe PPP's treatment approach in general, but many clients have special needs. A subjective review of cases identified five clusters of problems that required special handling, and the special issues associated with each are discussed below.

The first cluster relates to the special needs of parents and particularly mothers who are emotionally disturbed; these mothers have been studied extensively (Anthony, Koupernik & Chiland, 1978), and PPP's experience with them has been generally positive. Time and attention needs to given to the parent's own problems even if they are currently in treatment elsewhere, but it is also important to stress the child's needs for parental attention and parental responsibilities. Little progress can be made during the recurring crisis episodes, but the mothers in this group pick up new skills remarkably quickly when not stressed. It is very important to work on only one goal at a time however; proceeding too quickly or attacking more than one problem at a time can be a significant stressor in and of itself.

The parents whose primary difficulty relates to their cognitive limitations compose the second cluster. They are often highly motivated to avoid or prevent deficits in their children, but progress is still painfully slow. Criticism and correction are not effective, but praise and a desire to be "normal" are highly motivating. Typically many agencies and concerned family members are involved with these cases; their support and assistance are undoubtedly needed, but as a consequence the parent often receives conflicting advice. Perhaps because these families are under such close scrutiny, they also tend to have higher rates of termination of parental rights.

The third group is defined by the following adjectives: resistant, suspicious, limit testing, coerced and angry. Needless to say it is not easy to work with families in this cluster, and a special approach is needed. Praise tends to be rejected as an attempted manipulation, but brutal honesty is appreciated. Contracts should be used to make the inevitable negotiations explicit, and progress toward discharge is the best motivator. This is the one group with whom demonstration seems to be an effective teaching technique; resistant clients tend to observe closely and learn even if they do not demonstrate the new skills until much later, "when they want to."

The fourth group is characterized by disorganization. Families in this cluster often have no phone, no calendar, no budgeting skills, poor personal hygiene and poor housekeeping skills; indeed they have a general difficulty in coping. If

these problems are combined with others, like resistiveness, the prognosis is poor. Often children are removed after an eviction. Demonstrations are ineffective with this group, and written materials just get lost. Sometimes it is necessary to begin training in the clinic where there are fewer distractions; tangible rewards and "vacations" from treatment can be motivating, but improvement in one area is followed by deterioration in another.

The final cluster of problems is found in families with mothers who are socially isolated, passive, naive and easily used by others. There is no trouble in establishing rapport here, but the reasons for involvement must be continually restated. Contracting is useful if the mother's actual goals can be identified; it is not uncommon for this group to be ambivalent about change. Problems with spouses or friends are common and can easily distract from parenting problems, but it seems that the risk of abuse or neglect is greatest when the people causing problems leave the situation. Not surprisingly, these families tend to remain in treatment rather longer than average, and discharge planning must include development of other social supports.

EVALUATION AND CURRENT STATUS

Unfortunately there is relatively little evaluation data to support the observations and recommendations stated above. PPP is supported almost entirely by state tax dollars, and no funding has been allocated to permit a systematic evaluation; consequently there is no comparison group of randomly assigned families, no long term follow-up of treated families, sample size is distressingly small (67), and many of the behaviors PPP hopes to impact upon are known to correlate with age. What data are available come from the periodic reviews of cases in treatment and from retrospective assessments by staff. Given the methodological problems, this information must be interpreted very cautiously, but there are some indications of successful treatment.

Every six months children are tested with the Bayley Scales of Infant Development or Stanford-Binet, videotapes of mother - infant interaction are made, and PPP's Stimulation and Interaction Inventory and Physical Care and Safety Assessment are completed on the basis of in-home observations. Children treated between 1978 and 1982 showed an average gain of 11.9 points on the Bayley ($t = 3.41$, $p < .01$). More recently, a smaller (5.4 point) improvement has been noted; this is not statistically reliable, but the initial scores have also crept up into the normal range (94.9). The mothers' rates of verbal praise almost doubles from 12.2 times per hour to 22.8 times per hour in the first six months of treatment ($t = 2.60$, $p <$

.05), and over a longer period, significant increases in "joining" with the child are observed. Both mothers and children increase their rates of verbalization, and in-home observations substantiate increases in praise and in children's compliance. Globally, staff feel that about 90% of the families improve, and only 11% have had their children placed in foster care.

PPP is thus at a curious stage of development. It has existed long enough to develop a coherent treatment approach and assessment procedures that are relevant both to families needs and the services available. Yet it is still an "experimental" program, largely unproven. A great deal of public attention is being given to problems of child abuse and neglect, but in times of continuing budget austerity, programs as intensive (and costly) as PPP are difficult to justify. As with any prevention program, cost effectivness of the program is hard to establish. Thus it seems that, at least in Wisconsin, the near future will see development of small parent-support self help and volunteer programs rather than expansion of the PPP model. Some families can probably benefit from such an approach (Bavolek & Comstock, 1983), but it seems clear that a continuum of services is needed. Because of the other problems in their lives, multi-problem families need services that are more intense and focused than other families might. They face the same parenting issues as anyone else and need training in the same kinds of skills. Hopefully, the Primary Prevention Project's experience will provide intervention strategies to meet those needs in multiproblem families.

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